Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury Webinar Series

"Evidence-Based Management of Suicide Risk Behavior: A Guideline Perspective"

December 15, 2016 1-2:30 p.m. (ET)

Operator: Welcome and thank you for standing by. At this time, all participants are on a listen only mode. Today's conference is being recorded. If you have any objections you may disconnect at this time. Now I'd like to turn the meeting over to Major Pittman. Thank you, you may begin.

Maj. Pittman: Good afternoon and thank you for joining us today for the DCoE psychological health December webinar, Evidence-Based Management of Suicide Risk Behavior: A Guideline Perspective. My name is Major Demietrice Pittman. I'm a clinical psychologist and Chief of Implementation Science at the Deployment Health Clinical Center. I will be your moderator for today's webinar. Today's presentation is available for download from the file slot below. Before we begin, let us review some webinar details. If you experience technical difficulties, please visit dc.mil/webinars to accept troubleshooting tips. Please feel free to identify yourself to other attendees via the chat box, but refrain from marketing your organization or product. All who wish to obtain continuing education credits or a certificate of attendance and who meet eligibility requirements must complete the online CE evaluation. After the webinar, please visit dcoe.cds.pesgece.com to complete the online CE evaluation and download or print your CE certificate or certificate of attendance. The evaluation will be open through Thursday, December 29, 2016.

Throughout the webinar, you are welcome to submit technical or content related questions via the Q and A pod located on the screen. All questions will be anonymous. Please do not submit technical or content related questions via the chat pod. I will now move on to today's webinar, Evidence-Based Management of Suicide Risk Behavior: A Guideline Perspective. The Department of Defense, DOD, and the Department of Veteran Affairs, VA, formed a partnership in 1998 called a VA DOD Evidence Based Practice Work Group which developed clinical practice guidelines to improve the quality of care and health management across both the Veterans Health Administration and military health systems. Active participants in a group include multi-disciplinary experts from DOD, Army, Navy, Air Force and the VA.

The Defense Center for Excellence and the psychological health in a traumatic brain injury, DCoE, plays an integral role in this joint work group, mainly by developing clinical support tools to promote provider compliance with clinical practice guidelines in the psychological health positions. In January, 2015, DOD and VA released 4 clinical support tools

to promote compliance with the 2013 VA DOD Clinical Practice Guidelines for the Assessment and Management of Patients at Risk for Suicide. The tools feature evidence based practices to help health care professionals treat military members and their families at risk for suicide. The webinar will focus on how to access, implement and disseminate these tools. At the conclusion of this webinar, participants will learn to understand the joint partnership purpose, evaluate the role of the joint work groups, analyze commission input in the evidence based guideline development, know where to find implementation tools, education resources, and [inaudible 00:03:26] to implementation.

I would now like to introduce our presenters, Dr. Eric Rogers, Dr. James Sall, and Commander Angela Williams. Dr. Rogers has over 30 years of experience in the field of nursing. Presently, he is Director of Veteran Affairs Central Office, Office of Quality, Safety and Value, Evidence Based Practice Program, and the acting Senior Nurse Executive for the Office of Quality Standards in Programs.

Dr. Sall served 28 years in the U.S. Army. He became a nurse practitioner in 2000. After retiring in 2013, he joined the DOD Office of Evidence Based Practice. Dr. Sall is also on the faculty of Texas A&M, Corpus Christi, and San Antonio College. He has worked for the VA central office for 4 months, and worked on the VA DOD Clinical Practice Guidelines for 4 years.

Amanda Williams is a licensed clinical psychologist. She is a prior Air Force enlisted and has served in the United States Public Health Service since 2006. She's worked within the DOD since 2008 and arrived at DCoE in 2012. Amanda Williams currently serves as the Evidence Based Practice Chief at VA [inaudible 00:04:43].

Welcome, Dr. Rogers, Dr. Sall, and Commander Williams.

Dr. Rogers: Thank you, Major Pittman, I appreciate that. Good day and welcome, everyone. This is Eric Rogers and, as was noted, I'm the director for evidence based practice for Veterans Health Affairs. I also probably should share with this group that I didn't include in my bio that I also served in the army. I actually began my career as a combat medic during Vietnam and served through the first Gulf War. I guess I'm dating myself, but I'm glad to be here and I'm going to begin our presentation on Evidence-Based Management of Suicide Risk Behavior: A Guideline Perspective. Here are the authors for this presentation, which Major Pittman has very nicely introduced us all. I will speak for all of us. I do know that we have no disclosures for conflict of interest to claim today.

Maj. Pittman: Dr. Rogers, can you un-pause your camera, please?

Dr. Rogers: Okay. I will also apologize that I woke up this morning with a cold, so I will try very hard not to cough my way through this presentation. I apologize upfront if I have to pause for a moment. As we've identified the objectives,

you see them here on the screen. I'm not a big fan of re-reading objectives, but I am going to begin with an explanation and an overview of the VA and DOD clinical practice guideline partnership and a general overview of the process for guideline development. As you see here, and was previously mentioned, since 1998 Veteran Affairs and Department of Defense have had a very productive partnership in guideline development and implementation. A little bit of history there is that VA published their first clinical practice guidelines, evidence based, in 1996 and 1997. They were both cardiac related. It was ischemic heart disease and stroke rehab. That was because of those publications and that effort that VA and DOD decided that that's kind of costly to produce and it would be much better if we joined forces and worked together in that production. That's how our partnership began in 1998 and we've been through several iterations in growth, but we're now titled The VA DOD Evidence Based Practice Work Group.

The work group is responsible for collaborating on clinical guidelines and implementation to improve the quality of care and health management across both of our organizations. We know that clinical practice guidelines are very helpful to reduce variation in clinical care, both within our systems and across both of our systems. It also helps to reduce resource utilization and provide more consistent quality care. It's also a good way to help identify what future research goals are needed across both of our systems. The Evidence Based Practice Work Group is really kind of a governing body. They oversee the development process of our guidelines. They also make sure that we update and revise our guidelines in a timely manner. Normally speaking, we update our guidelines every 5 years and that is consistent with guideline standards, which I'll talk about here in a few minutes.

Also, at any point in time, anyone actually but usually it's what we call our champions, our clinical champions, can come to the Evidence Based Practice Work Group and say that there's been significant changes in our field. There's a landmark study or whatever, to say "You know, we shouldn't wait 5 years, it needs to be updated now," and we can do that. Also we will do an immediate update if a product or drug has been identified as dangerous or hazardous. We will immediately update that within our guideline. The VA DOD Evidence Based Practice Work Group reports to the VA DOD Health Executive Council, and in turn, they report to the Joint Executive Council.

The Institute of Medicine, in March of 2011, published a report called: Clinical Practice Guidelines We Can Trust. As I eluded, guidelines have been around for quite some time, at least 20 years. Actually, they became kind of popular in the '80's so more like 3 decades. But there was no standard for guideline development, so in 2011 The Institute of Medicine came together and issued a report on what makes a good guideline. Clinical practice guidelines, as we know, are recommendations that have actionable statements that are based on systematic review of the evidence and that's the key here, is based on systematic review of

evidence. They also consider the benefits and harms of that care and whatever options there might be. They came together to do this because a lot of the guidelines just weren't trustworthy. They were not based, necessarily, on evidence and didn't contain the parameters that were considered to be trustworthy.

What is a credible guideline? It does, like I said, include systematic review of the existing evidence that the panel, that makes up the guideline development is multi-disciplinary, and most importantly, that conflicts of interest have been identified and either eliminated or controlled for, and that it does include patient input because, after all, they're a major stakeholder in any clinical practice guideline that is developed.

Also, we need to be transparent, is what the IOM said, when it comes to credible guidelines. We need to be able to very clearly explain how we rated the evidence, how we came to the conclusions that we did, and that there is a very logical relationship between the recommendations and the evidence. Also, they need to be updated. They need to be timely in their update in that they're constantly monitored, basically. Specifically for the VA and DOD guideline process, we take a very strict approach to conflicts of interest. When we come together we have a multi-disciplinary team comprised of both VA and Department of Defense clinical experts. We call our chairs of those panels "clinical champions". In terms of our conflict of interest, the champions cannot have any conflicts of interest and serve on the guideline development. We don't have that strict approach to the actual work group members. However, given both the Department of Defense and the VA's uniqueness, it's very rare that we would have someone that actually has a conflict of interest on the work group. When those are identified, we take a look at that to see, are we able to mitigate that and work with it or control it, or is it of a nature where that's not possible, in which case they are removed from the guideline panel.

As I stated, our work groups are multi-disciplinary. They include medicine, nursing, pharmacy, social work, PT, OT, chaplains, patients, so they are very multi-disciplinary. Every one of our guidelines has that range of disciplines. One thing I noticed that's not on here that should be is that, in our next step, we do conduct veteran and patient focus groups. They're key stakeholders in this process and they're very valuable in helping us to identify what is important to them, the patient, in their care for whatever the situation is, and in this one, suicide. For this guideline, we actually did focus groups and spoke with patients from both the VA and the Department of Defense, including individuals on active duty as well as family members, in order to help us identify what those key questions are. From that, we identify they key questions that guide the evidence for review. On this guideline we had 10 key questions and those are what tells us what are the parameters for the evidence review that we are going to conduct.

We do review the evidence and we apply a grading system to it. Dr. Sall will speak to that here in a few minutes. From the evidence, the work

group then develops the recommendations and a treatment algorithm. That's one of the hallmarks for the VA and DOD clinical practice guidelines, is that all of our guidelines include treatment algorithms. It's an interactive process, and in that process we do develop several drafts of the guideline and they are sent out at various times, both within the VA and the Department of Defense for subject matter expert review. Then, ultimately, they're sent out externally to the appropriate professional organizations, other individuals in the community that are identified as experts in that field. We also send it back out to the patients and the family members that were part of the focus group in they key questions development so that they can see if we appropriately addressed their concerns and what they identified.

Ultimately, when we have the guideline finalized, it does go before the VA DOD Evidence Based Practice Work Group for approval. I will tell you, that is not an automatic process. We've had situations where guidelines have gone back repeatedly for additional edits and further work. We've even had a situation where we had a guideline that ultimately was never approved by the governing body. Trust me when I say it's not automatic. It's not a rubber stamp. They're looked at very rigorously.

Here is a listing, these next 2 slides, of our current guidelines. We actually have a total of 24 currently posted, and this number will fluctuate based on timing of removing guidelines that are outdated or adding new guidelines that have been developed. On this slide, you'll see the website for the Department of Defense to access the guidelines. It's at qmo.amed.army.mil. The next slide has the VA website on it. You can access either one of these. They'll be talked about a little further in the presentation, but if you're looking to order tools from the website you will need to use the DOD website in order to be able to access the shopping cart and order the tools. You'll see the current list of mental health related guidelines that are available.

At this point, I'm going to turn it over to Dr. Jim Sall, who will speak more to the specifics of the VA DOD Suicide Risk Behavior Guideline. Dr. Sall?

Dr. Sall: Thank you, Eric. I'll spend a few minutes talking about how we continue to meet those IOM standards and, in particular, how we met that with the suicide prevention guideline. This slide that's on your screen now has some thumbnails used with some of our behavior health and mental health CPG's that we have. Don't pay attention to the dates that are on there. I think my graphic specialist inserted some numbers that ... I don't know where he got those because the suicide guideline there in the center was approved in the fourth quarter of 2013. Bipolar is the oldest one, there on the left side, and that was approved in 2010. Then you've got major depression, that was approved in the first quarter of 2016. MTBI was also, our concussion there, was also approved in the first quarter of 2016. Substance use disorder was approved in the very late quarter of 2015 and then PTSD, there on the right side, is currently under update now. We expect that to be approved in the first quarter of 2017.

This next slide here shows the work group that developed the suicide prevention guideline. Typically we have about 20 subject matter experts, 10 from the VA and 10 from DOD. They are, as the IOM requires, in multi-disciplinary groups. This particular group included psychiatrists, psychologists, family physicians, nurse practitioners, pharmacists and psychiatric nurses as well. They all came together to review the evidence, come up with their recommendations.

We should talk a little bit about the scope of the problem. I believe that everybody is aware that suicide is a huge problem, both within the DOD, the VA, and really within American society in general. We know that it's the leading cause of the death within the DOD and it's not surprising today that it has surpassed combat deaths, but it may be surprising to some that it surpassed combat deaths during the height of all the conflicts that we have in recent years. It's also the leading cause of loss of productivity within the DOD and is the leading cause of preventable deaths amongst young adults within the U.S. population. That is a shocking statistic for me because you think about all the accidents and homicides that take place within our general society, and to think that suicide is a bigger problem than that is sometimes shocking. Then, of course, it's a big problem also for our veteran population, accounted for 20% of the suicide deaths within the U.S.

When we develop a guideline, and the suicide guideline was no different, we typically start by developing some research questions or key questions that we center the guideline around. When we develop those key questions, we use something called the PICO format. PICO stands for, P for population, I for intervention, C for comparison, O for outcome. Sometimes we also use a TNS, time and setting, as well if that's important in the development of that particular research question. With population we want to know, are we talking about VA patients, DOD patients, somebody who has got new onset suicidality or somebody who has had chronic suicidality? The intervention, are we talking about using a behavioral therapy, a psychotherapy, pharmacology to treat the suicidality, or perhaps a combination of those together to treat the suicidality? Then we use comparisons, so we may compare different treatment options or combinations of treatment options. Then, of course, we have to define the outcome we're looking for. Of course we are hoping to reduce suicidality, but maybe we're also hoping to reduce suicidal ideation or another type of outcome for that CPG.

Once we have our key question set or the research question set, then we need to do a complete systematic review of the literature. This is a huge process and, really, a very expensive process. We don't cherry pick our research studies that we evaluate. We do a comprehensive review. We're very fortunate in that we've been able to contract with an organization called ECRI Institute to do that evidence review for us.

ECRI, if you're not familiar with them, started out in the early ... That was a company that started out in the early '60's with a physician who, an ER

physician who was very frustrated that when he was trying to resuscitate a young child that the equipment he was using failed to work. So he started asking questions. How do I know that the equipment that we have here in the ER is going to work? How do we know that the way our crash cart is set up is the best way to have it set up? He started doing evidence reviews on his own to answer those questions and, of course, gained some notoriety with the answers that he got and then started getting requests from other organizations to study problems that they had. Anyway, it exploded until ECRI, now, is really the largest company in the world that does systematic reviews for a variety of companies, of which the VA and the DOD happen to be one of the companies that they work with.

They are a disinterested party. They are just a bunch of researchers in Pennsylvania that do a comprehensive review of the evidence. They also ensure that their team does not have any conflicts of interest to ensure that their review is unbiased. We set explicit parameters for those evidence reviews. We set the date and we set perhaps some other parameters, like a minimum time for results or a maximum time for results, looking out. We are very transparent in our research parameters and we spell those out clearly in the guidelines so that if another organization wants to come and see if they can get the same results from their literature review, they can reproduce that evidence for us.

Once we have the evidence collected, then we have an evidence chaperone and ECRI fulfills that for us as well. They bring the evidence to a face to face meeting where the subject matter experts gather and they do a summary presentation of the evidence. The evidence is also collated into large, spiral notebooks for the subject matter experts to examine and evaluate.

The next quote there, it shows how we grade the quality of the study. We use two methods. One is the grading to grade our recommendations and put them in a hierarchy. We also use the USPSTS grading system to grade the quality of the studies because, as you know, just because something is a research study doesn't mean it's a good research study. We have to actually evaluate those studies so that we can categorize them as either a high quality study or perhaps something of lesser quality. This next slide here is a pictorial representation of our evidence hierarchy. Of course you can see that randomized control trials and a meta analysis of randomized control trials are going to be the top of the evidence pyramid. Then, of course, the bottom of the pyramid, when there is no evidence, would be your expert opinion. Sometimes that's the only type of evidence that is out there and we will clearly state that as a research need for the future.

This next slide provides a numerical representation of our evidence grading. Those high quality, randomized control trials and meta analyses of randomized control trials will come out as level 1 evidence. Then, of course, your expert opinion falls down all the way to level 5 evidence. It's

interesting to note that, with suicide, you're going to find a lot of grade 3 and grade 4 evidence because, for ethical reasons, you could not to a randomized control trial for interventions for suicidality. For suicide, you're not going to ever find a randomized control trial. That was often lower quality evidence which we can't feel bad about because that's really all that ever will be available.

The quality of the evidence, we rate it as good or high, fair, moderate, or poor, low or very low. Good, high quality evidence, we feel confident that future research is unlikely to change the confidence that we have in the treatment effects for that particular study. If it's fair, we have a little bit of uncertainty inserted in that, our confidence. Then if you get down to low or very low, then we probably feel pretty confident that future research is either going to strengthen our confidence in that treatment effect or likely could also dissuade us from using that treatment in the future.

That talked about how we grade the studies. Now we're going to look at how we grade our recommendations. We use the grade approach for grading our recommendations. You can see there that ... It's kind of hard to see, but you can see that we have randomized controls, trials on the top there, and our confidence in the ... With the study design, we can see that our confidence is high, and all the way down to observational studies which, unfortunately, we find a lot with suicidality, that gives us a lower confidence in the treatment effect that we have. But just because something starts out with low confidence doesn't mean that it's always going to stay low confidence. There could be something that comes into play that could raise our confidence in that recommendation. If the studies showed that it had a huge treatment effect, it may have been an observational study but if you were observing 500 patients and 490 of them received huge benefits, then you could have a lot of confidence in that treatment effect. It's a combination of those factors that gives you the final rating of whether the evidence is high, moderate, low or very low.

The next slide shows, this is the USPSTS grading system for evidence. It shows that you can have grade A evidence all the way down to grade I evidence. Grade A evidence, when we've had that, that's a service or a treatment that you definitely want to offer because the effect is so beneficial for the population. If you get the B level evidence, that's probably pretty good for the population but not as strong as grade A evidence. Then you go down the scale here, C and D, and I, you can offer that but we're really uncertain about what the effects might be. There may be some minor benefit but we don't have a lot of confidence in that. Then, of course, expert opinion is going to fall outside the evidence scale.

The next slide here shows the algorithm that we have for suicide. This is assessment and management algorithm. We have a variety of boxes there that we use. The ones with the rounded rectangle, that represents a clinical state. Then the boxes with the square corners gives us an action to do. Then, of course, the hexagon is a decision state and there is going to be directional arrows coming out of the decision state, whether it is a

yes or no answer, to take you to the next part of the algorithm. By far, the algorithms are the most used piece of our clinical practice guidelines that we've developed because you can see, basically, the entire CPG in a snapshot view. You can have the confidence that if you walk your patient from the first spot through to the last spot, that you've given them the best evidence based care that's available for them.

It's also important that we talk about implementation of our guidelines, as I spoke to earlier. The algorithms are really the biggest piece, the number one utilized piece of our guideline, but truly guidelines are really not very effective unless they're embraced by the leadership, whether that's the military leadership or the VA leadership for that particular facility. It's also important to remember that our guidelines are strictly recommendations for care. There's a lot of reasons why you would stray from the guidelines. They are not standards of care, they are, specifically, recommendations for care. One of the biggest reasons you would stray from the guideline would be, perhaps, that the patient doesn't want to do a treatment that is recommended by the evidence. Maybe the evidence says that they should engage in behavioral therapy and they don't want anything to do with behavioral therapy for whatever reason. Or maybe the recommendation is that they should be on pharmacotherapy and they don't want to do that. It's important to remember that these are not mandates, that they're recommendations for care. If you're trying to stick to the guideline, it may be important that you note in your clinical note why you're straying from the guideline, especially if it's something that the patient is not willing to take on as a treatment.

We also try to develop toolkits to support the guidelines. One of those tools is something that we're going to speak to here in a few minutes, but all of our tools are available on the web. There's a DOD website, the top bullet there, and then there's also ... I'm sorry, the VA website is the top bullet and then the DOD website is that second bullet there. [inaudible 00:36:43].army.mil website. Typically when we develop a guideline we try to include a few metrics so that you can use automated systems, perhaps, to see how well the guidelines are being utilized. We try to develop provider material so that providers have something that they can use quickly as reference to ensure that they're complying with the guideline. We have pharmacy materials, a lot. Typically each of the guidelines has a chart so that providers have a quick reference on pharmaceutical options for treating a particular condition or disease. We try to develop patient information so that, as a provider is implementing the guidelines, there is something for the patient to see and educate themselves with so that they understand better the medical plan that's been developed for them by the provider.

We have many more resources. We have some videos that are also available on the web that can be used as CME or CNE material, offerings such as this. Then we also really work hard to make sure that we can put links to our clinical practice guideline in the electronic health records.

Truly, if we can get the links in those electronic health records, it makes the utilization of the guidelines seamless.

Also, for implementation, it's important to note that we have several manuals available to help both at the national and the facility level with implementation. We have the Champions Manual. Eric talked earlier about the guideline champion that helps to put and develop the guideline, helps put the guideline together and develop it. We also have champions at the local level, and this is a manual that's designed for those local champions. It's really important that you have a champion in each facility, somebody who is talking up their particular guideline to their peers, can maybe order supplies like pocket cards or CPG summaries for their peers to have as reference material, or perhaps even just talk about a particular guideline during staff meetings so that folks don't forget that there is a clinical practice guideline available for treatment of a specific disease. Then we have the DOD ran manual and then there's a VA ran manual that talks about the development of clinical practice guidelines and implementing them at the facilities.

Now we know that we have these guidelines and it's important to talk about how often they're routinely updated. Eric mentioned that we do update guidelines out of cycle if there is a huge change in treatment or if there's a product recall or something that is show stopping that needs to be changed in a particular guideline. But, routinely we update our guidelines every 3 to 5 years. Sometimes we can push that back a little further if we know that there hasn't been a lot of innovation with a particular disease or condition, but typically it's every 3 to 5 years. Then the next bullet there talks about when we will do an immediate update.

Okay, now I'll turn it over to Commander Williams and she'll talk about the suicide risk tools that we have developed.

Cmdr. Williams: Okay, welcome. My name is Commander Angela Williams, and for the next few minutes I'm going to be reviewing the 4 clinical support tools that align with the VA DOD Assessment and Management of Suicide Risk Clinical Practice Guidelines.

First I want to spend a few seconds talking about the intent of the tools. The first goals are to promote health care team compliance with the 2013 VA DOD Clinical Practice Guidelines for the Assessment and Management of Patients at Risk for Suicide. Also it brings together the practices to help healthcare professionals identify and treat service members and their families. It also facilitates the standardized treatment processes and the decisions for the healthcare team and patients who present with suicide risk. As well, it increases the suicide prevention knowledge for the healthcare team, the patient and the family member.

The first tool I'd like to review would be the Assessment and Management of Patients at Risk for Suicide Pocket Guide. This particular tool was created by the VA. Some of the key points about this tool, it is mainly

used by the primary and specialty care healthcare team. It's a double sided, accordion style pocket guide and, if I'm not mistaken, it should be able to fit snug like into a pocket, pants pockets. It outlines the key elements of the suicide risk guidelines and it includes key points like assessment and management of suicide risk within the primary care. It identifies your warning signs, your risk and protective factors. It also outlines the discharge and safety planning and addresses the evidence based treatment [inaudible 00:42:37] suicidal behavior.

The next tool is a patient tool. The title is Suicide Prevention: Overcoming Suicidal Thoughts and Feelings. This particular tool is a one page, double sided tool. It's mainly used by the health care team, and they use it or they can use to educate the patient on risk management, strategies to build inner forces of strength. It teaches the patient how to recognize warning signs, effective coping strategies, as well as the importance of treatment engagement.

The third tool we have is the safety plan worksheet. This is really a great tool but one important factor that's important for me to note, this particular tool is driven by the healthcare provider. What happens is, the healthcare provider, when they're sitting with the patient, they would actually sit down with the patient and actually go through step by step in completing this particular document. This particular tool is a single page, one sided tool. Again, it allows for the collaboration between the healthcare team and the patient to identify stressful triggers and warning signs, forces of support, coping strategies and ways to access healthcare assistance. It also helps, you can identify key family members or friends that you would like to identify if you're feeling suicidal. It also allows the patient to identify activities that tend to keep them more focused in a positive manner, where it keeps them more in a better mood. Then also, this is a really great tool.

Once it is completed, the healthcare provider should actually make a copy of the tool or scan it into the AHLTA medical records. At one point we were hoping to be able to get this put into AHLTA, where the provider could actually go in and type the information, but at this point that's still not accessible. So right now, once the tool is completed, it helps the provider to scan the tool into AHLTA and then also provide the patient with a copy of the tool. They can take that tool home, put it on their refrigerator, keep it handy in their pocket, in their purse, and that way they can easily have access to it when they need to refer.

The last tool we have is a family tool, and the title is Suicide Prevention: A Guide for Military and Veteran Families. This is a one page, double sided tool. The healthcare team can use this particular tool with family members to educate about suicide warnings, how to access care, appropriate treatment and ways to best help a loved one who is suicidal or in a crisis.

This particular slide is advertising where or how you can access these tools. The tools can be found in a couple of places. One, the U.S. Army

Medical Command has a website under the healthcare team. If you click that tab, you actually can then download the tools. You can also go onto the shopping cart, which is a part of the Army medical command website. If you have a Army, Air Force or I think Navy email address, you'll be able to order as many tools as you need to and then they'll actually ship them to you. Then for VA providers, you actually can go into the VA website, it's listed on the screen, and you can actually download the tools.

Right now I think we're going to pause and open it up to questions.

Dr. Sall: Are we answering the questions on the screen?

Maj. Pittman: No, I will get the questions for you, thank you.

Dr. Sall: Okay.

Maj. Pittman: All right. Thank you Dr. Rogers, Dr. Sall, and Commander Williams for your presentations. It's now time to answer questions from the audience. If you have not already done so, you may submit questions now via the question pod located on the screen. We will respond to as many questions as time permits. I saw two of the questions were just asking about where to locate or download to pocket guide. If you look in the files pod, you can actually download that guide and should be able to download it and save it to your computer. As well as, Commander Williams just gave the information on the last slide about where to order the tools. I went ahead and answered, it was a couple questions at the end that just came in.

All right, I'm going to move on to another question. One person says, "Terrific amount of scholarly work you are sharing here, thank you for that. How many marriage and family therapists are part of your inter-disciplinary team.

Dr. Rogers: Hi, this is Eric Rogers. It varies because we don't have the same team every time. It depends on what the guideline is and the disciplines that are needed for that guideline. But typically, because we try to keep the numbers reasonable in terms of a working group of a max of 20 work group members from both the VA and DOD side of the house, typically I would imagine it's 1 or 2 per the appropriate guideline. But it just depends on the individual guideline.

Dr. Sall: For this guideline, I don't know that we had a specific marriage or family therapist, but we did have a chaplain who does probably most of that work for the DOD on the guideline.

Maj. Pittman: All right. Thank you so much, you guys. I have another question for Dr. Rogers. Can you talk more about how you go about conducting your focus groups? Is an IRB needed?

Dr. Rogers: Good question. Actually, they're very informal and we have a contractor for guideline development. It's the Llewyn Group and they serve as our facilitators for the focus group. Because this is an informal group, we also adhere to the, I believe it's OPM. I always get them mixed up, but the requirement for paperwork reduction where we cannot have more than 9 participants at a time. We adhere to that and it is very much a convenience sample and so IRB approval is not required. But what we do in order ... How they're formed is that, at the very beginning, with the champions and the work group, depending on the topic, we ask "Where across the United States could we get a good representation from both VA and DOD for this particular topic?" Then a location is decided upon and then we work with local subject matter experts on both sides, VA and DOD, to help recruit patients for the focus group. Then the focus group is conduced and the work group members do generate a question guide for the facilitators to use, but it's very much a convenience sample and an IRB is not required for this, although we do work with local command to let them know what's going on. That's a good question, thank you.

Maj. Pittman: Thank you so much for that, great answer. I really appreciate it. I'm sure the person on the line does, too. We have another question. What are some current concerns with the suicide CPG's that may be up for evaluation, reconsideration, in the near future? This is for either Dr. Sall or Dr. Rogers. I don't know if you have the answers for that one.

Dr. Sall: Can you say the question again?

Maj. Pittman: Sure. What are some current concerns with suicide CPG's that may be up for evaluation or reconsideration in the near future?

Dr. Sall: That's a good question. I think there is more innovations each year regarding psychotherapies and behavioral therapies for the treatment of suicidality that will have to be incorporated into guidelines in the future. Probably the biggest concern about suicidality is that we know from the evidence that it tends to be an impulsive act. Future research is going to have to really help us focus in on how we address those acute acts. We know from the evidence that, typically, it involves some type of loss, whether that's a loss of a family member, loss of a spouse, whether through divorce or through death, financial losses. Those can all cause individuals to acutely start thinking about suicide. The key is to figure out, how do we create interventions with somebody that we may or may not see in clinic from the time that they started thinking about suicide until they actually commit the suicidal act?

Maj. Pittman: Thank you so much. This question is for any of the presenters. Thank you for the materials. [inaudible 00:53:59] describe what to do depending on level risk? Are there guidelines for the best way of asking a question to determine level of risk?

Dr. Rogers: I don't know if, Commander Williams, if you want to address that?

Cmdr. Williams: Repeat the question [inaudible 00:54:28]?

Maj. Pittman: Sure. I'll repeat the question. Do [inaudible 00:54:30] describe what to do depending on level risk? Are there guidelines for the best of asking a question to determine level of risk?

Cmdr. Williams: I think that's a really great question. That's a great question and I think, to make sure I give the right answer, I would want to take that back to the team and look at that. Then we can definitely respond back to that person with a response.

Dr. Sall: This is Dr. Sall. Ultimately, the guidelines are reviewing the evidence. We did review evidence and we will continue to review evidence in the future about: what are the best assessment tools for assessing suicidal risk. I would have to lean towards yes, the guidelines are an effective tool for measuring risk, because you're going to go to that section of the guideline and look at what tools were evaluated and what the evidence was on their effectiveness on measuring suicidal risk.

Dr. Rogers: This is Eric Rogers. To add on to that, when we did look at the evidence, we were not able to recommend one tool over another, based on the evidence. There wasn't any clear distinction that one was better than another for assessment.

Maj. Pittman: All right. Thank you so much. This question is actually about another CPG. Are you aware of a timeline for the revision of the bipolar disorder CPG?

Dr. Sall: Yeah. The bipolar CPG is actually scheduled to update in FY17, so I believe we're going to start work on that one in the summer of 2017. Eric, you can correct me if I'm wrong on that one.

Dr. Rogers: That's correct. It will be sometime after May.

Dr. Sall: There's a little bit of a delay on that, on CPG development for 2017, because we're going to be transitioning from one contract to another. We may not necessarily change contractors, but the current contract expires in June and then the next contract kicks off in July. Until that contract is awarded, we can't really go down the path of starting development on that particular CPG or the update of that CPG.

Maj. Pittman: All right. Thank you so much. I didn't know it was up for revision, that's really great. I have another question. Can you provide some examples of actual best practices of study that receive a high score and one that would not? Also, is it an individual decision on how to deviate from the guideline? I think this would be either for Dr. Rogers or Dr. Sall in terms of the studies.

Dr. Sall: I think they're talking about studies in relationship to suicide. You know, the problem with suicide is they were all low and very low quality studies

and there was a lot of expert opinion involved in that guideline. It has been a few years, so I can't particularly say what was the best quality study and the worst quality that we looked at, but that is clearly spelled out in the guideline itself. Off the top of my head I can't say which one it was. But, in reference to adhering to the guidelines, it shouldn't be an individual provider's discretion to deviate from the guideline based on their particular opinion. It really should be based on either an assessment they've made with a patient that is causing them to deviate from the guideline or the patient's preference itself that cause them to stray from the guideline. I don't know if that answers the question, but typically we recommend that folks adhere to the guideline unless there is a clinical reason or the patient preference to stray from it.

Maj. Pittman: All right, thank you. Another question asks is there measurement reliability standard or component used to assess modalities via algorithms?

Dr. Sall: We don't really have any assessment tools for ... I think, are they talking about for implementation of the recommendations. All of the modalities that are recommended in the guideline have some type of evidence behind them, whether it is high quality or low quality evidence. The recommendation typically has that stated with it, whether we highly recommend or have high confidence in the intervention, or whether we just have a moderate or low quality confidence in the intervention. Does that answer the question?

Maj. Pittman: I think it does. I'm sure if that person has more ... If you want to ask more, please submit an additional question through the question pod, establish your question if you don't feel like you got an appropriate answer. We'll move on to the next question. If that question comes back up and we need more detail, I will let you know. The next question says: when using this information, do you find that clients, patients, are willing to participate and stay engaged to reduce their risk of suicide, being that they do not have a lot of ownership in all of this? That can be for anyone.

Dr. Rogers: This is Eric Rogers. Can you repeat the question? I'm not sure that I caught the last piece of that.

Maj. Pittman: Sure. It says, when using this information, do you find that clients are willing to participate and stay engaged to reduce their risk of suicide, being that they do not have a lot of ownership in all of this?

Dr. Rogers: Again, that's very much an individual response. I actually don't deal in mental health specific. I'm a primary care provider, and I can just speak to my experiences with it. I've had very positive interactions with my patients related to suicide and this guideline. The feedback that I'm getting from my mental health colleagues, in terms of how patients are responding and their use of the guideline ... I'm not able to speak to anything specific that I could identify that would say this helped maintain therapeutic alliance better than something else, but just in general terms I've gotten very

positive feedback from my mental health colleagues and my own personal experience with individual patients has been good. I really could not identify for you something specific. Jim or Commander Williams could address that ...

Dr. Sall: I think we can say, in general, that our guidelines have been shown to increase patient satisfaction. I think you can translate that into, patients really appreciate if you can tell them, in clinic, the evidence says that this is really the best way to approach treatment of your particular condition. Then, after that, it really becomes dependent upon, what benefit does the patient feel from it? If they feel like they're getting benefit from it then they're going to be happy and they're going to want to continue with the treatment. If they feel like it is not benefiting them, then of course they're going to want to go down a different road.

Another thing that, as a primary care provider, that I found valuable from this guideline too, was that it opened up communication a little more with patients who might be depressed and perhaps even suicidal. In the past, when we had a patient in the clinic who would say something like, "I'd be better off dead," or something, the alarms would go off. You'd be immediately on the phone with behavior health, saying, "I've got a suicidal patient with me and they need an acute evaluation." Now we know, from reviewing the evidence, that just because a patient says that doesn't mean they're acutely suicidal. In fact, that can be quite a normal thing for somebody to feel when they're depressed. What should set off the alarms is if they say something like that and then they can also verbalize that they have a plan for committing suicide or they can verbalize that they've got easy access to weapons or something that they can use to implement the suicidal plan within easy reach. Then it becomes more of an alarming issue. I do believe some patients may appreciate the fact that they can talk about how they're feeling with their primary care provider without worrying that the fire alarm is going to go off because they say the wrong word. But I don't have direct evidence to back that up.

Maj. Pittman: Thank you, guys. I don't know if you have anything else to add to that, Commander Williams?

Cmdr. Williams: I think the only thing I was going to add is, we do know that a number of providers actually order the clinical support tools that align with that particular CPG. We do know, in relation to the one safety plan worksheet, providers tend to really like that worksheet. The one problem we've found is the amount of time providers have with each individual patient, so making sure that they always have time to be able to actually go through that worksheet. I think that's the one problem we've heard that can be a little difficult, having enough time to actually sit down with the patient and really be thoughtful about the information that is included. I just wanted to add that.

Maj. Pittman: Thank you. The next question, I think you can probably answer as well. Someone has a question of, how are the suicide risk clinical support tools

disseminated to providers and eventually to soldiers and family members? I know you just mentioned that people order. Are there other ways or other things, ways people get these?

Cmdr. Williams: Again, I think Dr. Sall and Dr. Rogers can maybe speak to this as well. We try our best to come up with different dissemination strategies to make sure that providers are aware of the tools. Again, you can go to the medcom shopping cart or you can download them off of the VA website. We tried to develop looping slides that will show on different ... I guess the different screens at the hospital. When you go to the different treatment facilities, sometimes they have the TV screens or monitors and we will sometimes have looping slides that will go through and be able to tell you about the different tools that are available. I think it has been a little more difficult for us to make family members more aware of the availability of these tools. Right now we've really been trying to strategize how we can do a better job with getting end user feedback and find out ways that we can make sure that family members and patients are aware that these tools are available from where they can get access to them.

Maj. Pittman: Thank you. The next question talks a little bit more about the safety plan, which you just mentioned a couple minutes ago. It says they noticed that there is a safety plan in the handout. Can you speak to the difference between this safety plan and the one created by family in brown? Commander Williams, or Dr. Sall or Dr. Rogers, do you have any answer to that question?

Dr. Sall: I'm sorry, could you say the question again?

Maj. Pittman: Sure. It says, can you speak to the difference between the safety plan that was developed and the one created by family in brown?

Dr. Sall: I'm not familiar with that other safety plan, so I really can't speak to it. Commander Williams, are you familiar with that other safety plan?

Cmdr. Williams: No, unfortunately I'm not familiar with it so I wouldn't be able to speak to it.

Maj. Pittman: Thank you guys for that. We'll move on to the next question. Another person wanted to know a little bit more about the tools as well. They say: one question I have comes from the perspective of my role as a provider supervising and with the technicians. What overall guidance or tools are there within the console? If it's in a suicide CPG that could be packaged for our enlisted [inaudible 01:09:20]? For example, as a reference for the suicide risk in an operational environment. It's kind of long, if you need me to repeat parts of that. They basically want to know if the provider, the supervisor visited, what kind of things could they use from the CPG that they could pull out, order their soldiers [inaudible 01:09:37].

Cmdr. Williams: Again, I would think that all 4 ... I would probably say the 3 tools, which would be the family tools and the safety plan worksheet. Then I think

there's one patient tool. I think all 3 of those tools would be really good tools for behavioral health techs. I think the provider tools, the first one, the accordion type tool, is really driven more for the providers who are going to be providing that direct patient care with that particular patient. While I know the behavioral health techs also provide some of that care, I think that one is really driven more towards the actual provider. But I definitely think the other 3 could be used by behavioral health techs, could be used in a kit that they can then use with patients. Again, I think the behavioral health tech, if they're working really close with the provider, could actually help with the patient in completing that safety plan worksheet. It would actually make more sense that maybe a tech would have more time to be able to sit with that patient to actually thoughtfully prepare that particular tool. I don't know if Jim and Eric, do you have anything else you want to add to that?

Dr. Sall: We do have that safety tool available, and it's on the DOD's website in a pdf version that you can type into and fill and then print and save. I could see how that would be valuable as well in a deployed environment, where you could have that loaded on the hard drives of your computers down range and then you could pull that up to use. We've also worked hard to get the guideline embedded into the electronic health record, but I think the deployed health record is called MP4. I'm not sure how much progress we've made in getting it embedded into that particular record.

Maj. Pittman: Thank you guys, both, for that answer. The next question asks about some research. Is there research found or used related to virtual behavior health in the management of suicide risk behaviors?

Dr. Rogers: This is Eric Rogers. I know that that was looked at during the development of this CPG. As Jim stated, it's been a little while and I don't remember the actual studies per se, but I do know they were included. Overall, I think most of it was rated as weak evidence. There might have been one, I think, that was rated as a high quality study. But it's becoming, as we all know, more and more popular, but at the time of this review there wasn't a whole lot of research on it. Like I indicated, it was low quality, but it was considered and it was included as part of the evaluation for the recommendation. I hope that answers.

Dr. Sall: That question comes up with all of our behavior health CPGs, really. I know we looked at that with major depression and we've looked at it with PTSD. The evidence always seems to be relatively the same, that those interventions are helpful but they're not as helpful as in person, face to face counseling or therapy. It seems like, again and again, the recommendation is that they should be used as an adjunct. If there's a long wait list to get in to see a behavioral health provider or if it's just not available in your area, then we recommend using that until somebody can see somebody live and in person.

Maj. Pittman: Thank you. Another question asks: once a person has been identified as high risk or suicidal and they are getting treatment, how often is the

suicide risk assessment done and how often is the safety plan reviewed and updated?

Dr. Rogers: This is Eric Rogers. Again, that's an individual basis. The guideline simply says that, for someone that's actively being managed for high risk suicide, that that evaluation and ongoing assessment is just that it is ongoing. You, the provider, will need to determine that based on the behavior of the patient and how risky you assess that to be. Correct me if I'm wrong, Jim, but I don't really recall that we gave a definitive timeline. We made the recommendation so that it allowed for that individual variability.

Dr. Sall: That's right. There was no evidence that said it needed to be done at a certain interval or a certain time period, and so we didn't really have any evidence to back up making a specific recommendation for a time or a time for reassessment.

Maj. Pittman: Thank you. For those of you who are working at DOD, there are some policies that dictate assessments within your current service branch. You should definitely look at those, because those would dictate how often you'd have to reassess the suicide risk. As he said, the CPG leaves it open, but your current organization may dictate that, or your current hospital. Definitely look into those.

The next question asks, do you address challenges to implementation? Do you feel this would be useful to highlight?

Dr. Sall: Typically the CPG doesn't address challenges to implementation. Eric, do you have any more information on that?

Dr. Rogers: No, I guess I don't. I didn't quite catch the last piece of the question, but if you're asking does the guideline itself address the challenge to implementation, no, it does not. But each of the services, including the VA, does have a plan for implementation, and hopefully that plan has identified the respective challenges and barriers to implementation. I think, across the board, it's no big secret that that's one of the toughest things to do. We can develop these and disseminate them, but getting them implemented and truly embedded out in the field sometimes is quite a challenge. The guideline itself doesn't speak to it, but each service, I believe, does or should have an individual implementation plan. I hope that answers the question.

Dr. Sall: Leadership is always the biggest challenge to implementation. If leaders at facilities believe in the guidelines and promote the guidelines, then implementation tends to be smoother. Believe it or not, there are some leaders at some facilities that are not big believers in guidelines and then it's really challenging to get them implemented at those facilities.

Maj. Pittman: Thank you guys. We've got a ton of questions. We really only have time for one more. I really appreciate everyone submitting their questions but this will be the last question. It says: what do you think of suicide

intervention using peer support models, like assist, to apply suicide intervention training skills as effective trainings for peer support suicide first aid intervention. They're popular trainings in the National Guard and other veteran service organizations.

Dr. Rogers: This is Eric Rogers. Since I'm not really a mental health specialist, I'm going to defer that answer to someone else who is. I do know that we did look at peer assistance programs and it is addressed within the guideline. I'll open that up. I don't know, Commander Williams, if you have enough of a background there to address that, or someone else?

Cmdr. Williams: No, actually, I couldn't really speak to it.

Maj. Pittman: Thank you guys. Whoever asked that question, it was a great question so you definitely should go and look up some of their research and what was in the guidelines about some of those programs. It kind of can give you a little bit more information. All of those are located, the guidelines and the tools, are located in the files pod, in case you didn't see those. Then we also have a resource list.

That concludes our webinar. I want to thank you guys again for having the webinar. After the webinar please visit ecoe.pds.pesgece.com to complete the online CE evaluation and download or print your CE certificate or certificate of attendance. The online CE evaluation will be open through Thursday, December 29, 2016.

Again, thank you to our presenters, Dr. Rogers, Dr. Sall, and Commander Williams. Today's presentation will be archived in the lovely webinar section of the DCoE website. To help us improve future webinars, we encourage you to click the feedback tools that will open in separate browser on your computer. To access the presentation and resource list for this webinar, visit the DCoE website at dcoe.mil/webinars. A downloadable audio podcast and edited transcript of the closed caption text will be posted to that link.

The chat function will remain open for an additional 10 minutes after conclusion of the webinar to permit attendees to continue to network with each other. The next DCoE TBI webinar, Traumatic Brain Injury and Substance Abuse: This Is Your Injured Brain on Drugs and Alcohol, is scheduled for January 12th, 2017, from 1:00 to 2:30 pm Eastern time. The next DCoE psychological health webinar, Substance Abuse and Anger Management, is scheduled for February 23rd, 2017, from 1:00 to 2:30 pm Eastern Time. Again, thank you for attending and have a great day.

Operator: This concludes today's conference call. Thank you for participating. You may disconnect at this time.